STATE BOARD OF OPTOMETRY
2450 DEL PASO ROAD, SUITE 105, SACRAMENTO, CA 95834
P (916) 575-7170 F (916) 575-7292 www.optometry .ca.gov

CERTIFICATION OF 5,000 PRACTICE HOURS

If you practiced at numerous locations during the time period being documented, use a separate form for each practice location.

This certification is for use in establishing eligibility to become licensed in California based upon number of hours practiced and must accompany the Application for Licensure by an Out-of-State Licensed Optometrist.

1. Name: (First) (Middle) (Last)

2. Address: (Number & Street)

(City) (State) (Zip) (Telephone)

Were you self-employed? ☐ Yes ☐ No

- If you answered "No" proceed to Section I and have the employer or custodian of records* complete and certify the information.
- If you answered "Yes", go to Section II

SECTION - I

Practice address during the period indicated below:

(Number & Street)

(City) (State) (Zip) (Telephone)

From: (mm/dd/yyyy)	To: (mm/dd/yyyy)	Total hours

Business name and address, if different from the practice address.

(Name of business)

(Number & Street)

(City) (State) (Zip) (Telephone)

SECTION - I (continued)
Employer/Custodian of Records:

I certify under penalty of perjury under the laws of the State of California that I am the custodian of records of the business listed above, and that the above is a true and correct representation of the records of the business.

_____ _____
Printed/Typed Name of Certifying Person Signature of Certifying Person

_____ (_____)_____
Date of Signing Telephone Number

SECTION - II Dates and hours of practice.

NOTE! IF THIS APPLICATION IS BEING MADE PURSUANT TO A FEDERALLY DECLARED EMERGENCY AS STATED IN BUSINESS AND PROFESSIONS CODE SECTION 3056, PLEASE INDICATE BELOW:

☐ YES (If yes, please call the Board at (866-585-2666 for information)

☐ NO (If no, please continue)

From: (mm/dd/yyyy)	To: (mm/dd/yyyy)	Total hours:	State and License Number:
From: (mm/dd/yyyy)	To: (mm/dd/yyyy)	Total hours:	State and License Number:
From: (mm/dd/yyyy)	To: (mm/dd/yyyy)	Total hours:	State and License Number:

I declare under penalty of perjury under the laws of the State of California that the answers given by me, employer, or custodian of record in completing this application are true and I understand and agree that any misstatements of facts herein may be cause for the denial of my application for licensure t or for subsequent suspension or revocation of a certificate of registration to practice optometry in California if one is granted to me.

_____ _____
Signature of Applicant Date

*THE CUSTODIAN OF RECORDS is a person or institution that has charge or custody of documents, papers, or other valuables.